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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/09/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
OP Transforaminal ESI @ Left L3/4

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Orthopedic spine surgeon, practicing neurosurgeon

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Cover sheet and working documents
Utilization review determination dated 06/07/12, 05/09/12
Office visit note dated 04/25/12, 12/28/11
MRI lumbar spine dated 11/09/11
Initial consultation dated 02/29/12
Physical therapy note dated 02/29/12
Psychological interview dated 02/29/12
Reconsideration dated 05/15/12

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male whose date of injury is xx/xx/xx. On this date the patient was driving his truck when the truck tipped over. The patient reports injury to his neck, left shoulder and low back. Treatment to date is noted to include physical therapy and medication management. MRI of the lumbar spine dated 11/09/11 revealed a 3 mm left lateral disc protrusion and annular fissure at L3-4 which contacts the left L3 nerve root distal to the neural foramen but does not produce significant stenosis. At L4-5 there is a 3 mm broad based posterior disc protrusion and annular fissure plus mild hypertrophy of the posterior elements producing mild right foraminal stenosis. Follow up note dated 04/25/12 indicates that the patient underwent approximately 6 sessions of physical therapy and has been placed back at full duty work. The patient underwent previous epidural steroid injection and reported no significant improvement from the injection. On physical examination there is tenderness to palpation in the left paraspinous region and left gluteal region. He is able to forward flex to around 40 degrees without pain but with a pulling sensation in the back. Extension does cause significant pain. On physical examination straight leg raising is negative. Deep tendon reflexes are +2 bilaterally. Sensation is decreased along the dorsum of the foot and lateral

foot on the left and intact otherwise. There is 4+/5 left tibialis anterior weakness, and otherwise 5/5 throughout.

Initial request for transforaminal epidural steroid injection at left L3-4 was non-certified on 05/09/12 noting that the patient's physical examination does not establish the presence of active lumbar radiculopathy, and the submitted MRI does not support the diagnosis. The patient reported no improvement with previous epidural steroid injection. The denial was upheld on appeal dated 06/07/12 noting that there is no clear documentation of a recent comprehensive clinical evaluation of the patient from the provider or treating physician that addresses the proposed epidural steroid injection with a negative straight leg raising test. There is no documentation provided with regard to the failure of the patient to respond to conservative measures such as home exercise program, activity modification and medications prior to the proposed surgical procedure including the procedural report and objective response from the previous epidural steroid injection.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Based on the clinical information provided, the request for OP transforaminal epidural steroid injection at left L3-4 is not recommended as medically necessary, and the two previous denials are upheld. The patient is noted to have undergone previous epidural steroid injection; however, there is no procedure report submitted for review documenting the level/s and date of this injection. Note dated 04/25/12 indicates that the patient reported no significant improvement from the previous epidural steroid injection. The Official Disability Guidelines support repeat epidural steroid injection with evidence of at least 50% pain relief for 6-8 weeks. The patient's physical examination reports negative straight leg raising and intact deep tendon reflexes. Given the current clinical data, the requested epidural steroid injection is not indicated as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)